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Research and Practice With Families in Foster Care

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Foster care is designed for children who cannot safely remain in their birth parents' homes, usually for reasons relating to child maltreatment. About half of the 400,000 children living in out-of-home care in the US live with unrelated foster parents (Administration for Children, Youth, and Families [ACYF], 2013); others live with relatives in kinship foster care, some live in group homes, and others live in alternative transitional settings. Foster parents are usually strangers to the children they care for in their homes. They typically care for three foster children at a time, and approximately one-third of foster parents have five or more children living in the home, including their own birth children (US Department of Health and Human Services [DHHS], 2001).

Foster care is considered a temporary situation, where custody of the child is transferred from the birth parent to the state, with the caregiver serving the substitute care needs of the child until the birth parent can change the circumstances that necessitated care. Birth parents may have drug or alcohol addictions that interrupt their parenting abilities, serious mental health or health difficulties, or they may be absent due to temporary incarceration or other reasons. Although birth parents use the services proffered by the state, children remain in the homes of substitute caregivers—foster parents—until it is safe for them to return to their family of origin or to secure adoption, often with their foster parent or with another alternative caregiver. As such, there are two family systems engaged in foster care: that of the birth family and the foster family.

To better understand the unique circumstances and needs of foster families and birth families, we first provide an overview of the roles and responsibilities of birth parents and caregivers vis-à-vis child welfare agencies and the courts; we exclude kinship caregivers and caregivers provided in institutional settings (e.g., group homes). We then offer a profile of foster parents and birth parents to contextualize some of their caregiving challenges, needs, resources, caregiving practices, and home environments. The children in care are also described, because they

typically present with a wide range of complex caregiving requirements. The special circumstances of foster children require thoughtful integration into an existing family system; the combination of children's and birth parents' special needs, court requirements, and family dynamics have important implications for the clinical supports many caregivers require.

Defining the Roles and Responsibilities of Caregivers

During the time children are living with foster parents, birth parents are required by the juvenile court (sometimes referred to as a dependency court) to engage in services designed to increase the safety of their parenting skills and their home environment. For example, these services might include drug treatment, counseling, parent education, or anger management classes. Every six months the courts review the progress that birth parents have made to determine whether the home situation and/or parenting capacities have changed sufficiently to return the child to their care.

Ample evidence suggests that this is a time of great emotional turmoil for birth parents. Involuntarily separated from their children, the range of emotions birth parents experience is vast. Some authors have reported their emotional landscape as sad, worried, nervous, bitter, angry, guilty, empty, or numb (Jenkins, 1969). Many birth parents report a feeling of severe isolation (Levin, 1992), particularly those who indicate the need to sever relationships with friends or family members who may be contributing to their unsafe parenting practices (Maluccio, Walsh, & Pine, 1993). Birth parents may feel powerless against the significant authority of the state (e.g., Levin, 1992), and some may feel a sense of ambivalence about their parenting role, in part relieved of the temporary responsibilities associated with care (e.g., Bicknell-Hentges, 1995). Other authors have chronicled the various stages parents endure as they move from an initial period of pure survival without their children to adaptation, acceptance, and, finally, strength (Lietz & Strength, 2011).

While birth parents manage the substantial transitions associated with the loss of their child, foster parents play at least two essential roles in the lives of children—one that might be characterized as bureaucratic and the other as familial. Bureaucratically, they serve as agents of the state, securing children's well-being on behalf of the government. In this regard, they might have responsibilities to transport children to visitation sessions with birth parents, to submit documents to court, or to attend case conferences regarding the child's needs. At the same time, they serve as substitute parents, playing protective, loving, and nurturing roles, and also taking on all of the activities and responsibilities of effective parents.

Foster parents are asked to make unconditional emotional commitments to the children in their care. However, caregivers also must be prepared to let go of children when and if reunification with birth parents

can be safely accomplished. According to the federal government, the median length of stay in foster care is 13 months (ACF, 2013). A closer examination of data at the state level suggests great variability in length of stay depending, in part, on the age of the child, the reason for the child's initial removal, the child's race/ethnicity, and/or the child's disabling condition (Needell et al., 2013). Some foster parents decide to make life-long legal commitments to the children in their care; when reunification is not possible, these families may elect to adopt their foster child. For roughly half of the children who are initially placed in foster care, reunification occurs (ACF, 2013; Berrick, 2008), so transitions out of the foster care home are fairly likely. Evidence from several studies suggests that foster parents keenly feel a sense of pain and grief at children's departure from their homes (e.g., Buehler, Cox, & Cuddeback, 2003; Rhodes, Orme, & Buehler, 2001).

Characteristics of Foster Parents

Foster parents are drawn to this service for a variety of reasons, the most commonly reported including a sense of duty; an obligation based on their faith commitments; their love for children; a desire to make a difference in the lives of children; or a desire to parent after their own children have grown and left the home, as a way to recreate the family life they once enjoyed (Buehler et al., 2003). Although some anecdotes indicate that foster parents provide care for financial gain, little research supports this view.

Although we know a good bit about the motivations for care, we know less about the characteristics of caregivers or their caregiving context. Research on the characteristics of foster parents is remarkably sparse. Most studies involve small samples drawn from local jurisdictions. The limited national studies that shed light on the characteristics of foster parents paint a similar picture. Foster parents are usually over 40 years old, and rapidly increasing proportions are single parents. Although a large majority are married, a minority are college educated, and about half work outside the home in addition to their caregiving responsibilities (Barth et al., 2008). About 40% of foster parents are African American, 42% are Caucasian, and about 11% are Hispanic (Barth et al., 2008). Foster parents are, on average, a financially disadvantaged population (O'Hare, 2008). According to one national study, approximately 20% of foster children live in homes with incomes below the federal poverty line, another 40% live in homes below 200% of the poverty line, 25% of caregivers were unable to regularly pay their rent or mortgage, and 25% experienced food insecurity (National Survey of America's Families, 2002; US DHHS, 2001). Based upon caregiver self-report, some evidence indicates that foster parents have similar health and mental health needs as other adults in the US population, although their physical health

reportedly declines as they age (approximately 10% of foster parents are over the age of 60), whereas their mental health reportedly improves (Barth et al., 2008). Compared to the average American parent, one might characterize foster parents as older, possessing fewer financial and educational resources, and living in homes with many children.

Characteristics of Birth Parents

Birth parents whose children are taken into foster care are notably different from average parents in the US population. According to a national study of children involved with the child welfare system, almost two-thirds of birth parents whose children have been placed in foster care have a need for mental health services, and over one-half need substance abuse services; approximately two-fifths need assistance with housing, and two-fifths also have a need for legal assistance. About two-thirds receive help with domestic violence-related problems, and over three-fourths of caregivers receive financial and/or employment assistance (Dolan, Smith, Casanueva, & Ringeisen, 2012).

The Nature of Caregiving

It is widely believed that foster parenting is more challenging than parenting (Megahead & Soliday, 2013). The demands on foster parents go well beyond what children ask and need of them and extend to the social service agency, the courts, allied service providers, birth parents, and the community. In this regard, the views of researchers and practitioners on the characteristics of high-quality care typically align. Principles of effective care include supporting children's development, honoring children's birth families, celebrating children's cultural heritage and traditions, accepting loss, and serving as team members (Buehler, Rhodes, Orme, & Cuddeback, 2006; Shlonsky & Berrick, 2001). Also important is the need to attend to children's experience of integrating into a new family, responding sensitively to the "triangle" of birth parent(s), birth child, and foster family, and assertively pressing others to respond to children's needs (Berrick & Skivenes, 2012).

Agency staff now have available tools to help them identify foster care applicants with the characteristics and skills necessary to offer effective care, measuring several of the domains generally considered essential to high-quality care (Buehler et al., 2006; Orme, Cuddeback, Buehler, Cox, & LeProhn, 2007). Information is also becoming available that can differentiate the caregivers who may be capable of providing the extra care required of special-needs children (Orme, Cherry, & Cox, 2013). Some of the domains of care captured in these instruments include: (1) providing children with a safe and secure environment; (2) providing children with a nurturing environment; (3) promoting children's educational

attainment and success; (4) meeting children's physical and mental health needs; (5) promoting children's social and emotional development; (6) supporting children's cultural needs; (7) supporting permanency planning by connecting children to safe, nurturing relationships intended to last a lifetime; (8) managing ambiguity and loss for the foster child and foster family; (9) growing as a foster parent by pursuing training, developing needed skills, and managing the complexities of the fostering role; (10) managing the demands of fostering on personal and familial well-being; (11) supporting relationships between foster children and their birth families; and (12) working in partnership with other members of the foster care team.

Of concern is whether and how often social service agencies use these criteria in their selection of foster parents. We know that foster parent applicants must, at a minimum, meet criteria set by each state and become licensed prior to caring for a child. The licensing criteria for each state differ somewhat, but they largely center on the safety of the caregivers' home. For example, the home is determined to be safe if second-floor windows can be locked, pools are fenced, and there is a working smoke detector (Lee, 2001). Home studies are typically conducted by a social worker to assess the caregivers' ability to parent, and minimal standards of "adequacy" typically prevail. However, some argue that the home study may not be suitable for uncovering the special talents and the important weaknesses of some foster parents (Crea, Griffin, & Barth, 2011).

Others argue that minimum standards based on safety criteria are insufficient, given the significant emotional and behavioral challenges and needs of the children in care and the compelling state interest in securing foster children's well-being (Shlonsky & Berrick, 2001). Yet, demand for caregivers is high, the pool of interested adults from which to select is limited, and social service agencies struggle to recruit and retain an adequate supply of caregivers (e.g., Ciarrochi, Randel, Miller, & Dolnicar, 2012; Cox, Orme, & Rhodes, 2002).

Although little is known about the applicant pool of foster parents, research by John Orme and his colleagues suggests that many foster parent applicants possess family characteristics that might pose hazards to children. In one study (Orme et al., 2004), about half of married couple applicants showed three or more problems in "psycho-social functioning," less than 10% reported problematic levels of verbal abuse from a spouse, and 8% of women and 15% of men reported high levels of depression. In the same study, among adults selected to serve as foster parents, 25% of foster families included an adult scoring in the "problematic range" on a standardized scale measuring empathy.

More recent research by these authors (Orme & Coombs-Orme, 2014) showed that a substantial minority of applicants present with troubling characteristics, even after participation in a widely known foster parent training program. In this study, 20% of applicants had psychological

problems characterized as in the "clinical range," a full 33% exhibited low levels of empathy toward children, and 20% held expectations for children's behavior that were developmentally inappropriate. Applicants with a "nonproblematic family context" were more likely to be enrolled as foster parents, but a sizable minority of applicants with a "problematic family context" were also accepted into services.

Research based on a national sample of caregivers underscores the concerns of many practitioners who work with foster parents. According to Barth and colleagues (2008), the caregiving environments in foster care for children over age 3 is notably inferior to the average American home environment. Specifically, the average foster parent provides a home life significantly less cognitively stimulating than the home life that a typical American child enjoys. Also, too many foster parents simply do not enjoy the role they play in children's lives. In a study of foster parents largely drawn from one state, approximately 40% indicated that they were not satisfied with their parenting role and/or did not experience pleasure associated with this role (Crum, 2010).

There is much to be concerned about regarding caregiving practices, psychological resources, and home environments in many foster homes. Available evidence suggests that additional strategies must be developed to recruit a robust foster parent applicant pool so rigorous selection criteria can be applied and only the most effective caregivers selected. Instead, many agencies likely compromise these criteria and dip deeper into their applicant pool than they would like in order to secure beds for children needing care.

In spite of the known weaknesses in the foster parent population, it is important to acknowledge the exceptional care many foster parents provide. Identifying these caregivers' characteristics and needs can aid recruitment efforts and the development of appropriate supports (Berrick, Shauffer, & Rodriguez, 2011), because effective caregivers play a vital role in the service delivery system for children. Findings from one study (Cherry & Orme, 2013) revealed that only about 20% of all foster parents in a single jurisdiction provided care for almost 75% of all the children in foster care. This minority of foster parents experienced fewer placement disruptions and adopted twice as many children. Other characteristics of the "vital few" included more positive parenting attitudes, more available time to provide care, more formal support for their care, more stable home environments, and fewer hours working outside the home. In a cross-country comparison of highly effective US and Norwegian foster parents, we found remarkable similarities in caregiving (Berrick & Skivenes, 2012). The strategies caregivers employed could be generally described as falling into affective and behavioral domains. Although some of the affective characteristics (e.g., parenting with respect and humility) might be less malleable or subject to change, the behavioral characteristics (e.g., advocating for the child or developing strategies

during the first days in care to ease the child's transition) are "teachable" and can be developed with appropriate supports.

These promising findings shed light on what it takes to develop a system of quality care, because they speak to caregiver *abilities* as well as caregiver *capacities*. Polgar (2001) previously suggested that foster parents' abilities include those attributes that they bring to the caregiving experience. However, their *capacity* for care derives from the qualities that can be developed and supported through the social worker and/or clinical relationship. Reflecting on the work of Cherry and Orme noted above (2013), foster parent *abilities* might include a stable home environment and (possibly) positive parenting attitudes (though some might argue that these are capacities responsive to outside support). Certain foster parent *capacities* can be developed with outside services and time available to care for children, more formal supports, and fewer hours working outside the home.

Rycus and Hughes (1998) made the distinction between "minimum" and "desired" standards for foster parents, emphasizing that all caregivers should possess minimum standards; desired standards and behaviors might be a goal shaped by collateral service providers. Unfortunately, the use of a minimum standards approach in foster care likely results in care meeting basic licensing criteria for safety—a clearly inadequate standard for vulnerable children with significant histories of trauma.

Meeting the Needs of Special Children in Foster Care

The demands of daily care for foster children are extremely high, regardless of whether these children reside with birth or foster parents. Trauma, abuse, or neglect that would signal a need for foster care also leave lasting effects on many children (Hazen, Connelly, Kelleher, Landsverk, & Barth, 2004). The great majority of foster children have health, mental health, developmental, or behavioral needs that can be quite complex. Some estimates indicate that between 25% and 67% of foster children cope with emotional or behavioral challenges (Farmer et.al., 2001; McMillen et al., 2005); other studies show that foster children often experience acute and chronic health conditions as well as developmental disorders (e.g., Schneiderman, Leslie, Arnold-Clark, McDaniel, & Xie, 2011).

Because of their special needs, the requirements for providing effective care are high. Birth parents reunifying with their children may need to be especially prepared to respond to these high-demand children. Further, due to their multiple and complex biological and emotional challenges, foster children often need fierce, astute advocates to press for required services, regardless of whether their advocates are embodied in their birth or foster parent. For foster caregivers, the challenges of

serving high-needs children are coupled with caregivers' daily caregiving tasks being rarely rewarded with respite, the taxing nature of the emotional demands of care, and often confusing interactions with child welfare agencies and courts. Foster parents' greatest frustrations come from unresponsive social service systems that do not necessarily put the needs of children first, and unresponsive social work and clinical staff who do not rapidly reply to their calls for help (Shlonsky & Berrick, 2001; Fisher, Gibbs, Sinclair, & Wilson, 2000). Foster parents often report feeling disrespected and unacknowledged for the unique insights that they can provide regarding the children in their care (Burgess, MacDonald, & Smith, 2003), and studies consistently show that foster parents do not feel as though they are treated as equals in the coordinated team responses that are frequently required for effective services (Fisher et al., 2000; Shlonsky & Berrick, 2001). Demands on foster parents can also include stressful relationships with birth parents, placement moves (whether requested by the foster parent or required by the agency), child maltreatment allegations lodged against them by angry or confused children, and acrimonious or conflicted relationships with social workers (Buehler et al., 2003; Coakley, Cuddeback, Buehler, & Cox, 2007). Nonetheless, the rewards of caregiving are high, and effective foster parents frequently speak of the multiple rewards they experience from their role with children (Berrick & Skivenes, 2012). In particular, research consistently shows that foster parents' greatest satisfaction comes from the children they care for daily (Buehler et al., 2003).

Managing Family Life in Foster Homes

The rewards associated with caregiving are many, but challenges relating to foster care can affect family dynamics as a whole. Without sufficient support, these stressors can result in poor outcomes for children. Foster care places significant demands on any family—demands on time, finances, emotions, and other material resources—stressors that might not otherwise be present. Existing research suggests that in spite of the many benefits associated with fostering, caregiving may also increase family and marital conflict (e.g., Brown & Calder, 2000; Seaberg & Harrigan, 1999). Poland and Groze (1993) found that about two-thirds of caregivers indicated that fostering did not improve family relationships. Also, serial caregiving—providing care to multiple children over periods of time—may be especially disruptive as families reconfigure daily routines and activities to account for their newcomer members (Seaberg & Harrigan, 1999).

Most troubling is that some of the effects on family life are the perceived or actual challenges foster children can bring to the relationship between foster parents and birth children (e.g., Baring-Gould, Essick, Kleinkauf, & Miller, 1983). Some evidence indicates that placement

instability is associated with a foster home in which the foster parents' birth children also reside (Rock, Michelson, Thomson, & Day, 2013). These challenges may arise from the difficulties caregivers face managing the competing demands of their own children and foster children. Studies examining the effects of foster care on birth children point in a similar direction: caregivers worry that birth children have to compete for their attention and that their relationship with their birth children may be negatively affected. They also have concerns that birth children learn inappropriate behaviors from foster children, that they are prematurely exposed to serious life issues, or that their personality will be negatively affected (e.g., becoming more withdrawn, angry, or jealous; e.g., Broady, Stoyles, McMullan, Caputi, & Crittenden, 2010; Younes & Harp, 2007).

Importantly, the literature on the effects of foster care on family life also offers as many glimpses of hope as it does the tribulations of care. Research typically shows that many foster parents highlight the positive impacts foster children have on family life. For example, birth children are variously described as more giving, compassionate and accepting, empathic and mature, and generous and responsible after experiencing foster care in their family (e.g., Broady et al., 2010; Younes & Harp, 2007). Birth children are also reported to gain new appreciation for their family and claim a higher degree of emotional closeness (e.g., Poland & Groze, 1993; Younes & Harp, 2007).

The research literature that features foster children's experiences in care is largely positive. In general, studies show that the majority of children in foster care (and kinship care) are satisfied with their living circumstances, have positive relationships with their caregivers, and that their experience in care is improved over the circumstances of their birth families (e.g., Chapman, Wall, & Barth, 2004; Dunn, Culhane, & Taussig, 2010; Fox, Berrick, & Frasch, 2008). Yet, these studies also point to common themes of dissatisfaction among many foster children, including their sense of powerlessness about decisions made on their behalf and insufficient contact with birth families. At a clinical level, studies of foster children suggest that the demands of integrating into a new family are emotionally taxing. In addition to learning the rituals and routines of their new family (Hojer, 2004), children in foster care may experience loyalty conflicts between their original feelings of love and affection toward their birth parents and newly developed feelings of affection and care toward their new families (Mehta, Baker, & Chong, 2013). These loyalty conflicts are considered prevalent for many children in care and frequently cause a high degree of discomfort or emotional pain (Rittner, Affronti, Crofford, Coombes, & Schwam-Harris, 2011). The degree to which children's relationships with their foster family can be supported and strengthened is likely to have an important impact on their experience

in care and their outcomes from care (Chapman et al., 2004; Fernandez, 2007). Similarly, the extent to which foster families can support children's contact with and connection to birth families may help children manage these dual relationships (Sinclair, Barker, Wilson, & Gibbs, 2005).

Training and Support for Foster Families

Given what is known about the challenges of providing care and children's significant need for thoughtful, responsive, sensitive caregiving, providing the best training and support for these efforts is needed. Dorsey and colleagues (2008) examined the research on foster parent training and suggest that the two most widely used foster parent training programs—PRIDE and MAPP—have no proven effects. Because the programs are assumed to be effective, and participant satisfaction surveys suggest that they are helpful, infusing new, evidence-based approaches into training efforts on a large scale will prove to be challenging. Nevertheless, promising new approaches are available. New approaches rely on foster parent training coupled with coaching, supervision, or close support provided by clinically trained therapists or social workers. Specifically, programs showing the strongest effects on improving foster parents' positive parenting strategies and reducing behavioral challenges among children can be used with birth parents or with foster parents. Importantly, these programs share some common features. Parent–Child Interaction Therapy and The Incredible Years, both evidence-based parenting programs that rely on training and intensive coaching or supervision, are shown to reduce behavior problems in children and increase the use of positive parenting techniques and better co-parenting strategies among foster parents and birth parents (e.g., Linares, Montalto, Li, & Oza, 2006; Timmer, Urquiza, & Zebell, 2006). Chamberlain's Multidimensional Treatment Foster Care (MTFC) includes training (based on social learning theory), and it is coupled with regular supervision and support (e.g., Chamberlain, 1994, 2002). Drawing on attachment theory, Mary Dozier's work with foster parents caring for very young children includes a 10-week in-home training series where foster parents can practice their newly developing skills in the presence of support staff (e.g., Dozier, Dozier, & Manni, 2002; Dozier, Higley, Albus, & Nutter, 2002b; Dozier et al., 2006). More recent work by Chamberlain and colleagues shows the value of a modified MTFC approach with foster parents. In the KEEP model (Keeping Foster Parents Trained and Supported), caregivers receive extensive training (approximately 16 weeks) coupled with homework and regular telephone calls from KEEP staff. Randomized trials show effects on positive parenting, children's behavior, placement stability, and the likelihood of reunification for children (Chamberlain et al., 2008; Price et al., 2008).

Other models showing important effects rely less on training but focus on foster parent support. One approach to providing additional supports and enhanced stipends to foster parents showed effects on reducing children's challenging behaviors (one comparison group received higher stipends with no increased support, while the other comparison group received usual stipends and supports) (Chamberlain, Moreland, & Reid, 1992). The research in this area is still new, but the signs are promising and suggest that training alone is likely to offer little benefit to foster parents. However, training plus support and/or enhanced stipends may significantly improve the quality of foster care.

Therapeutic services may also be offered to foster families and are typically offered to many birth families. The most rigorously tested therapeutic intervention is the use of Parent–Child Interaction Therapy (PCIT), developed first for birth parents and their children, but also adapted for use with foster parents. Emerging evidence shows the promise of PCIT for reducing foster children's challenging behaviors (e.g., Timmer et al., 2006). Some research also points to the potential of filial therapy to improve the relationship between adolescent foster children and their foster parents (Capps, 2012). Overall, however, more research is necessary to secure a solid evidence base in this area of practice.

Conclusion

Foster care is the critical backbone of the child welfare system in the US. In spite of its many flaws, it is fundamental to the care of children and is not likely to disappear. Because the stakes are so high, as some of the most vulnerable children in the US live in America's foster homes, efforts to improve foster care should be a high priority for all of the service providers who touch this system.

The research presented here provides a road map of sorts, as it can direct family therapists to the clinical services that might offer the greatest benefits to families. First, the extensive literature on family practices that maximize children's opportunities for social and emotional well-being typically point to the role of parenting, family functioning, marital well-being (in two-parent families), temperament, social support, positive mental health, and material resources (for a review, see Orme & Buehler, 2001). These are the characteristics of parents that child welfare agencies should try to diligently recruit, and these are the conditions therapists should engage in promoting.

Next, child welfare agencies must make greater efforts to thoughtfully screen applicants for their *abilities* to provide effective care—those affective characteristics that some parents enjoy such as commitment, confidence, affection, and acceptance. The therapist's role that can complement the child welfare agency's duty is to support foster parents' *capacities*—those caregiving characteristics that can be learned,

practiced, and supported. The new foster care models that are showing positive effects all have common elements that include close consultation, supervision, and support (e.g., Chamberlain et al., 2008). Foster parents can learn how to develop more effective parenting skills, and they can be better prepared for the emotional challenges that often accompany care. Clinical support, focused specifically on the early experiences of family reformation to help new children integrate into existing families and to help families fully accept and integrate new children into their lives, can help reduce many of the stressors foster parents report, both marital and intrafamilial. In particular, intentional supports for birth children and the birth child/foster mother/foster child triangle may be especially useful. Similarly, clinical attention targeted to the birth mother/foster mother/foster child triangle may also support the porous relationships that are the signature of the foster care experience.

Child welfare agencies could do a great deal to improve the *bureaucratic experience* of foster parents. Examples might include treating caregivers with respect and as valued team members, promptly returning phone calls, providing adequate subsidies, and making reasonable (as opposed to unreasonable) demands on caregivers. As an important complement, clinical services can be used to greatest effect in supporting the *familial experience* of care by supporting the complicated family relationships that must be shaped, negotiated, and renewed with children's entries into, and exits from, the family. With attention to foster parents' *abilities* and *capacities* and support for the *bureaucratic* and *familial* aspects of the care experience, the overall quality of foster care will improve, and foster children will be more likely to enjoy the rehabilative and restorative care they need to grow and thrive.

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